IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

ANNETTE C. ANDERSON, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner, Social Security Administration, Defendant.	No. CV-08-3026-HU OPINION & ORDER

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HUBEL, Magistrate Judge:

Plaintiff Annette Anderson brings this action for judicial review of the Commissioner's final decision to deny disability insurance benefits (DIB) and supplemental security income (SSI). This Court has jurisdiction under 42 U.S.C. § 405(g).

All parties have consented to entry of final judgment by a Magistrate Judge in accordance with Federal Rule of Civil Procedure 73 and 28 U.S.C. § 636(c). For the reasons explained below, I affirm the Commissioner's decision.

PROCEDURAL BACKGROUND

Plaintiff protectively filed for DIB on January 6, 2005, and for SSI on June 27, 2005, alleging an onset date of September 20, 2000. Tr. 13, 51-54.[1] Her applications were denied initially and on reconsideration. Tr. 13, 22-25, 541-43.

On July 17, 2007, plaintiff, represented by counsel, appeared for a hearing before an Administrative Law Judge (ALJ). Tr. 557-73. On August 14, 2007, the ALJ found plaintiff not disabled. Tr. 10-21. The Appeals Council denied plaintiff's request for review of the ALJ's decision. Tr. 6-9.

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[1] In a February 18, 2005 disability report form (SSA-3368), plaintiff lists her onset date as June 30, 2002. Tr. 65. No explanation is given for the discrepancy in onset dates.

FACTUAL BACKGROUND

Plaintiff alleges disability based on a severe skin condition and the pain, itching, and other effects of this condition. Tr. 18. In her February 18, 2005 disability report form, she lists the following as the illnesses, injuries, or conditions that limit her ability to work: "Nervousness, rashes, diabetes, high blood pressure, OVARIAN CYST, MIGRAINE HEADACHES, ANXIETY, DEPRESSION, ADD." Tr. 65.

At the time of the July 17, 2007 hearing, plaintiff was thirty-six years old. Tr. 561. She has an associate's degree in liberal arts. Tr. 571. Her past relevant work is as an accountant for an electrician, assistant to the director of nursing at a college, medical billing assistant, retail cashier, chiropractor assistant, customer service, microfiche technician, switchboard operator, mail room clerk, and personal care attendant. Tr. 66-68, 85-109, 114-25.

I. Medical Evidence

The medical records begin with a November 10, 2001 emergency room visit for a toothache. Tr. 375-79. There is no mention of plaintiff's skin disorder other than her report of taking prednisone, a glucocorticoid steroid used to treat skin conditions, for allergies. Id. In a December 4, 2001 emergency room visit for pain while urinating and a bad cough, she reported taking prednisone for a skin rash. Tr. 371. The chart note from that visit also reveals the presence of a diffuse, heavy, red rash which plaintiff reported as chronic. Id.

On August 3, 2002, plaintiff presented to the emergency room

complaining of a flare-up of her eczema[2] and severe itching. Tr. 359. She reported a long-standing history of eczematous dermatitis for which she is usually on 20 milligrams of prednisone daily. Id. However, she further reported that she stopped taking the prednisone when she found out she was pregnant, because of the possibility of it causing a cleft palate defect to the fetus as a result of first trimester exposure. Id. She wondered if she could now resume taking prednisone and an antihistamine, which she reported helped her intense itching. Id.

On physical examination, the physician found generalized lichenification[3], particularly around the bilateral periorbital area of the face and the flexor creases of the upper and lower extremities. Tr. 360. There was erythema (diffused redness over the skin), with multiple abrasions caused by plaintiff's scratching, as well as shedding of the epidermis. Id. She was diagnosed with eczema, and advised to resume the 20 milligrams of prednisone daily, and to take the antihistamines Claritin or Benadryl for her severe itching. Id.

Plaintiff appeared at the emergency room again on September 18, 2002, complaining of flu-like symptoms. Tr. 355-57. Her past

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[2] "Acute or chronic cutaneous inflammatory condition with erythema, papules, vesicles, pustules, scales, crusts, or scabs alone or in combination. They may be dry or with watery discharge, with thickening, infiltration, and more or less itching or burning." Taber's Cyclopedic Medical Dictionary 452 (Clayton Thomas ed., F.A. Davis, 14th ed. 1981).

[3] Thick, leathery skin; usually the result of constant scratching and rubbing, and a common consequence of atopic dermatitis. www.medterms.com; see also Taber's 815 (defining "lichenification" as "[c]utaneous thickening and hardening from continued irritation.").

medical history mentions severe, diffuse eczema. Tr. 356. The chart note indicates she was taking prednisone and Benadryl. Id. Her skin was noted to have chronic erythema with eczematous changes. Id.

On November 12, 2002, plaintiff went to the emergency room for nasal congestion and throat swelling. Tr. 352-53. Her past medical history noted eczema, and the chart record states she was taking 20 milligrams of prednisone per day, as well as the antihistamine Zyrtec. Tr. 353. On physical examination, it was noted that she had a chronic, red rash over her face consistent with eczema. Tr. 354. Plaintiff was diagnosed with uvulitis and given antibiotics. Id.

On February 27, 2003, plaintiff presented to the emergency room with a complaint of abdominal pain. Tr. 349. By this time, plaintiff had delivered her baby. Tr. 350 (referring to her as postpartum, but no date of delivery noted). Her past medical history states she had a history of chronic skin inflammation, involving the whole surface of the skin and characterized by redness and abundant shedding of the epidermis, for which she was on chronic prednisone therapy, Zyrtec, and a non-steroidal anti-inflammatory (NSAID) medication. Id. On physical examination, she had a generalized, erythematous skin eruption with scaling off of dead tissue, discolored spots of skin, and skin abrasions caused by scratching, with no signs of superinfection. Tr. 351. The physician's diagnosis and treatment related only to plaintiff's abdominal complaints, with no apparent treatment for her skin condition. Id.

Plaintiff returned to the emergency room on March 17, 2003,

for abdominal pain. Tr. 342-48. Her history included chronic dermatitis, as well as her current medications of Zyrtec and prednisone. Tr. 343. Her skin was reddened with scratch marks over most of her body. Tr. 344. She had various radiological studies performed in an effort to search for the cause of her pain. An ovarian cyst was found on a pelvic ultrasound. Tr. 348. She was discharged with acute abdominal pain of unclear etiology, although possible early appendicitis is noted. Tr. 342. A report dated the following day states that the appendix was normal. Tr. 340. Another report dated the next day indicates she had bilateral ovarian cysts. Tr. 339.

On July 26, 2003, plaintiff went to the emergency room for body aches, a total body rash, and itching. Tr. 324-25. Plaintiff was seven weeks pregnant and presented to the emergency room "with an exacerbation of her eczema secondary to withdrawal from steroids during her pregnancy." Tr. 325. On examination, her skin had diffusely red, multiple epidermis abrasions, eczema from head to toe, which was worse on the backs of her legs and the back of her body. Tr. 325. She was treated in the emergency room with a variety of medications including NSAIDs, antihistamines, corticosteroids, opiod analgesics, and anti-anxiety medications. Id. She had "excellent results." Id.

On August 2, 2003, plaintiff was admitted to the hospital for treatment of cellulitis. Tr. 319. She had a diffuse body rash and severe itching. Id. She also had some skin breakdown with scabs all over her body including her trunk, extremities, chest, and abdomen. Tr. 320. The assessment was severe eczema and cellulitis. Id. She was treated with intravenous antibiotics,

anti-anxiety medication (also used to treat itching), corticosteroids, and Dilaudid or morphine for pain. Id.

On September 19, 2003, plaintiff presented to a different hospital's emergency room because of pain and itching. Tr. 251-54. The impression was of an exacerbation of her chronic dermatitis. Tr. 252. She was prescribed an antihistamine, an anti-anxiety medication, and a corticosteroid mediation. Tr. 253-54.

She returned to the emergency room on September 30, 2003, because of itching. Tr. 248. The impression was of severe dermatitis. Id. She was again prescribed the same medications. Tr. 248-50. She was discharged home with instructions to follow up with a high-risk obstetrician that date. Tr. 250.

Plaintiff returned to the emergency department twice in October 2003 for dermatitis exacerbations. Tr. 240-47. On October 4, 2003, the impression was of chronic dermatitis with recurrent exacerbations associated with pregnancy. Tr. 245. She was given the same medications she received in her prior visits. Tr. 247. On October 8, 2003, she presented with complaints of itching and red skin. Tr. 241. The impression this time was of severe dermatitis and severe itching. Id. She was given an antihistamine and a corticosteroid. Tr. 243. On November 5, 2003, plaintiff's skin was reported to be pink with no breakdown. Tr. 238.

On January 14, 2004, plaintiff returned to the emergency room with a generalized rash. Tr. 230. At the time, she was taking prednisone, an antihistamine, and an anti-anxiety medication. Id. The impression was noted as severe dermatitis and "toxic" dermatitis. Tr. 230. Plaintiff was given a corticosteroid, an antihistamine, and morphine. Tr. 232.

On January 20, 2004, plaintiff delivered her next child, by cesarean section, at approximately 34 weeks gestation as a result of fetal distress. Tr. 217-18, 220.

On May 22, 2004, plaintiff returned to the emergency room for itching and redness, having run out of her prednisone three days earlier. Tr. 207-08. She had diffuse eczema to her torso and received an antihistamine and prednisone. Tr. 208. On June 17, 2004, her skin was reported as pink and flushed, but with no breakdown. Tr. 203.

On February 14, 2005, plaintiff reported to the emergency room with a rash. Tr. 276. She had run out of her medications two days earlier. Id. She had a diffuse erythematous rash, very dry and flaky skin, and evidence of lichenification with linear scratch marks scattered on her legs and arms. Tr. 277. After thirty minutes of intravenous medication, she was markedly improved. Id. She was discharged with a prescription for prednisone, 30 milligrams daily. Id. She was instructed to follow-up with her regular physician to arrange for a referral for allergy testing. Id.

In April 2005, plaintiff was pregnant again, this time with twins. Tr. 265, 271. On April 21, 2005, she presented to the emergency room complaining of a rash. Tr. 271. She was quoted in the chart note from that visit as saying that "my rash always gets worse when I'm pregnant." Id. Plaintiff received medications, a prescription for an antihistamine and prednisone, and instructions to follow up with her primary care provider. Tr. 269.

Dr. Beatrice C. Kalata, M.D., had been plaintiff's treating physician from September 20, 2001, to June 30, 2004. Tr. 280.

Curiously, none of her office visit chart notes are in the record. Plaintiff offers no explanation for the omission. However, there is a statement from Dr. Kalata dated May 25, 2005, in which she states that she first saw plaintiff on September 20, 2001, for complaints of chronic rashes all over her body. Id. The last time she saw plaintiff was June 30, 2004. Id. Dr. Kalata includes a review of systems and diagnoses, without citing to a particular date on which they were rendered. Id. She notes that plaintiff had multiple red, elevated areas on her upper and lower extremities. Id. She diagnosed her as having chronic urticaria[4] and atopic dermatitis. Id. At the time of her writing, May 25, 2005, Dr. Kalata had heard that plaintiff was seeing another doctor for her skin problem. Id. She also stated that plaintiff's prognosis was guarded. Id.

Plaintiff moved from California to Oregon in the late spring of 2005 and saw Dr. Stephen L. Nelson, M.D., at the Family Practice Group in Medford on June 18, 2005. Tr. 461. The chart note lists Dr. Ashley Peterson as plaintiff's primary care provider. Id. Plaintiff saw Dr. Nelson for a problem unrelated to her skin, but his chart note remarks that her skin was diffusely pink. Tr. 462.

On August 17, 2005, Dr. Jeri Mendelson, M.D., a dermatologist, saw plaintiff for her atopic dermatitis. Tr. 540. Plaintiff was still pregnant with twins. Id. Plaintiff reported that she had had the skin condition most of her life and the only thing that made it better was steroid use. Id. She referred to having used

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[4] "A vascular reaction of the skin characterized by the eruption of pale evanescent wheals, which are associated with severe itching." Taber's 1523.

some topicals in the past and a worsening of the condition in the winter. Id.

Plaintiff was currently taking prednisone and Benadryl. Tr. 540. The physical examination revealed erythema and scaling in large plaques on both upper extremities, the chest, upper back, abdomen, and the lower extremities. Id. Plaintiff also had lichenification of the eyelids, on the central cheeks, and on the upper forehead. Id. She had redness with scale there as well. Id. The rest of the face, eyelids, scalp, lips, and neck were clear. Id.

In her assessment and plan, Dr. Mendelson remarked that plaintiff was weaning off prednisone. Id. Dr. Mendelson gave plaintiff an anti-inflammatory steroid medication in cream or lotion form, for her body. Id. She also put plaintiff "in UVB narrowband." Id. She further recommended that plaintiff use 1% hydrocortisone (a topical corticosteroid medication) on her face. Id. Plaintiff was to return to the clinic as necessary. Id.

On August 22, 2005, plaintiff called and reported to Dr. Mendelson that she had "mixed connective tissue disease." Tr. 539. Dr. Mendelson noted that "[w]e have been treating her in correspondence with Dr. Dryland with several medications." Id. There are no records in the administrative record of any visit with Dr. Dryland. In her chart note entry regarding this phone call, Dr. Mendelson noted that plaintiff takes 40 milligrams of prednisone daily and reported she was out. Id. She was going to call in a prescription of 80, 10-milligram pills, with refills. Id. Plaintiff was to follow-up as necessary. Id.

On September 13, 2005, Dr. Mendelson's office entered the

following in plaintiff's chart:

> 9/13/5: [Plaintiff] called today wanting Dr. Mendelson to fill out papers so [plaintiff] could collect disability due to her skin cond. [A]fter speaking w/ Dr. Mendelson, this is not anything that she thinks should be done. [P]t was not very happy hearing this [and] she states she had recieved [sic] disability for this for the past 7 years. I again told her this is nothing that Dr. Mendelson is willing to do. She could ask her [primary care] doc. [P]t will [follow up as needed].

Tr. 539.

On September 16, 2005, plaintiff saw Dr. George E. Campbell, D.O., in Jacksonville, Oregon, to establish care and to seek treatment for right wrist pain. Tr. 533-34. At the time, she was twenty-eight weeks pregnant with twins. Id.

On November 15, 2005, Dr. Campbell saw plaintiff for two conditions which arose during her pregnancy. Tr. 531. She had delivered her twins by caesarean section two weeks earlier. Id. First, he noted that she was hypertensive during the third trimester. Id. Dr. Campbell assessed her as having postpartum hypertension. Id. He continued her on an anti-hypertension medication. Id.

Dr. Campbell also noted that plaintiff had developed gestational diabetes while pregnant. Id. He assessed her with postpartum hyperglycemia, rule out diabetes. Id. He also noted that she was taking 40 milligrams of prednisone daily, for her eczema, which she had been doing for a number of years. Id. He indicated that plaintiff needed to explore alternatives to glucocorticoid therapy if she appeared to be persistently hyperglycemic. Id.

On January 20, 2006, plaintiff reported experiencing chest pain. Tr. 529. Dr. Campbell indicated that plaintiff now had

persistent adult onset non-insulin dependent diabetes. Id. She was still hypertensive as well. Id. However, in the problem list portion of the chart, he noted that the hypertension was "benign essential" and that the diabetes was borderline. Tr. 528.

On January 30, 2006, Dr. Campbell noted that plaintiff presently had a lichenified rash involving the arms and anterior upper trunk areas, neck, and face, with no secondary infection. Tr. 523. He prescribed the same non-steroidal lotion that Dr. Mendelson had prescribed, to be applied twice per day. Id.

On February 9, 2006, Dr. Campbell noted plaintiff's eight-year history of taking 40 milligrams of prednisone daily. Tr. 521. He noted that her dermatitis on that date was "rather marginally controlled." Id. He noted that in the past, she had tried a different non-steroidal cream intended to relieve mild to moderate eczema symptoms, which reduced inflammation, but caused itching. Id. He also noted that in the past, she had not seen either an endocrinologist or a rheumatologist. Id. He encouraged her to see her dermatologist again. Id. He noted the possibility of a rheumatology and endocrinologist referral, but decided to wait until she saw the dermatologist. Id.

On February 16, 2006, plaintiff went to Dr. Campbell to follow up regarding her diabetes and to discuss social security. Tr. 517. Dr. Campbell noted a flare up of her dermatitis, including a "recrudescence of inflammatory dermatitis" which was bodywide. Tr. 518. He noted that this "appears to be her typical pattern only with exacerbation." Id. There was no secondary infection. Id. Dr. Campbell increased her prednisone to 60 milligrams per day until "response" was obtained, followed by tapering by 1 milligram

every two to three days. Id.

On March 9, 2006, Dr. Campbell noted that plaintiff's atopic dermatitis was long standing and required ongoing corticosteroids for treatment. Tr. 515. He further noted that her prednisone dose was back to 40 milligrams daily and that her dermatitis was "back to baseline." Tr. 516.

On March 14, 2006, Dr. Campbell wrote a letter to plaintiff's attorney. He stated:

> I . . . have been treating Ms. Anderson since September 16, 2005. Approximately ten years ago she was diagnosed with a severe and resistant form of atopic dermatitis which has required longterm fairly high dose corticosteroids for treatment. It has become apparent that this condition, with marginally effective treatment for it, resulted in a significant effect on this patient's ability to perform normal job functions and indeed day to day activities of daily living. She finds it difficult to perform chores about the house and is ultrasensitive to household products. Her last work experience was in 2002 as a medical front office person. She had to stop due to severe and unremitting dermatitis (Code 8.05). In addition she has significant side effects to corticosteroids: elevated blood pressure, elevated blood sugar, weightgain, loss of visual acuity, decreased ability to concentrate, mood fluctuations, difficulty writing and in some cases, difficulty walking. At this point the estimated longterm prognosis is continuation of the above detailed symptoms for at least the next twelve months and in all likelihood this appears to be developing into a lifelong condition. She also requires ongoing consultation with a dermatologist with increased frequency of surveillance due to the necessity of taking high dose corticosteroids for the condition. In my opinion the above medical condition suggests that she would be an appropriate candidate for Social Security disability.

Tr. 404.

On May 19, 2006, plaintiff returned to Dr. Peterson at the Family Practice Group in Medford. Tr. 485. Interestingly, the chart note indicates that she did not have a primary care physician at the time, even though she had previously seen Dr. Nelson at that

clinic eleven months before and Dr. Nelson's chart note referred to Dr. Peterson as plaintiff's primary care physician. And, until recently, she had been cared for by Dr. Campbell in Jacksonville. At her visit with Dr. Peterson, plaintiff complained of migraines. Id. She was seventeen weeks pregnant. Id. She stated that her migraine frequency had increased during pregnancy. Id. She was given oxycodone and ibuprofen. Id. There is no mention of any skin condition or skin medications. Id.

On September 14, 2006, plaintiff delivered her baby by caesarean section at approximately thirty-four weeks gestation because of placenta previa/accreta.[5] Tr. 423-24. Surgical notes from the delivery and the hysterectomy performed at that time state that plaintiff's ovaries were normal. Tr. 422, 423-24.

On December 8, 2006, plaintiff saw Dr. Tom Margulies, M.D., at the Family Practice Group in Medford for sciatic pain, and pain radiating to her thigh. Tr. 480-81. Plaintiff reported a history of severe eczema, requiring hospitalizations for intravenous steroids, and a ten-year use of prednisone. Tr. 481. She also reported having no known complications as a result of the steroid therapy. Id. Given her long-term use of steroids, Dr. Margulies was concerned that she had a compression fracture or other pathologic disorder of the lumbar spine. Tr. 482. He also thought it was possible that she had a ruptured disk. Id. He planned to ask the Oregon Health Plan to pre-authorize physical therapy and an

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[5] Placenta previa is a placenta which is implanted in the lower uterine segment. Placenta accreta is a placenta which has invaded the musculature of the uterus and as a result, separation of the placenta is very difficult or impossible. Taber's 1107-08.

MRI. Id.

The MRI revealed mild stenosis at L1-2 through L4-5. Tr. 489. There was also mild bilateral foraminal narrowing at L3-4 through L5-Si. Id. No focal neural impingement was seen. Id. There were no findings to definitively explain the right radiculopathy. Id.

X-rays were negative and revealed no compression fractures or subluxations. Tr. 490.

On January 31, 2007, plaintiff saw Dr. Peterson to follow-up on her complaints of migraines. Tr. 474. She complained of headaches approximately twice per month, with Percocet (a brand name of a drug containing both oxycodone and acetaminophen), helping sometimes, but not always. Id. On physical examination, Dr. Peterson noted plaintiff's "[p]rofound exzematous changes" on plaintiff's face, neck, and arms. Id.

Dr. Peterson continued to recommend Percocet, ibuprofen, and an NSAID for plaintiff's migraines, as well as Maxalt, a drug used to treat acute migraine headaches. Tr. 476. For the dermatitis, she advised plaintiff to try and use creams as much as possible to reduce the use of oral steroids. Id. Dr. Peterson dropped plaintiff's prednisone prescription to 30 milligrams per day and ordered an anti-inflammatory cream called Lidex to be applied twice daily on her body, as well as a non-steroidal lotion to use twice daily on her face. Id. She also ordered her to have an allergy profile obtained. Id.

On March 13, 2007, plaintiff saw Dr. Peterson again, to follow-up from her previous visit. Tr. 469. They discussed her diabetes and her use of prednisone. Id. Plaintiff reported that she tried to go to 30 milligrams per day of prednisone, but her

eczema flared up when she did so. Id. Her allergy screen was negative. Id. Dr. Peterson strongly advised her to try to taper the prednisone to 35 milligrams daily. Id. She also recommended that plaintiff start taking Glucophage, an oral diabetes medication used to control blood sugar, and work on her diet. Id.

The next day, March 14, 2007, plaintiff returned to the Family Practice Group and saw Physician's Assistant Denise Ledbetter for follow up on some lab tests. Tr. 465. Ledbetter remarked that plaintiff's eczema was stable. Id. On physical examination, Ledbetter noted an eczemetous rash on the flexor areas of plaintiff's arms and legs. Id.

On March 27, 2007, plaintiff met with diabetes educator Joy Cook, R.N., at the Asante Diabetes Care Center. Tr. 491. Plaintiff reported that she had not been testing or managing her diabetes since her last baby was born six months earlier. Id. She further reported that she began taking Glucophage one week earlier, with no unpleasant side effects. Id. Cook reviewed basic diet information with plaintiff and gave her written information as well. Id. Plaintiff was instructed to return in one month with blood sugar and food logs so her control could be evaluated. Id. There is nothing in the record suggesting plaintiff did return as requested.

Plaintiff saw Dr. Mendelson again on May 1, 2007, for a skin examination following the excision of a squamous cell carcinoma from her arm. Tr. 538.[6] Dr. Mendelson noted that plaintiff had

[6] Because the record does not contain any medical records from the excision procedure itself, it is unknown who performed it.

severe dry skin at the time, for which she recommended Cetaphil cream. Id. She discussed getting plaintiff off prednisone. Id. Her chart note ends by stating that she would see plaintiff back again as necessary. Id. There are no further medical records.

II. Plaintiff's Testimony

At the hearing, plaintiff testified that she had seven children, ages thirteen, eleven, four, three, twenty-month old twins, and a ten-month old. Tr. 562. She can write, unless her hands are cracked making it hard to hold a pen, and she can perform basic addition and subtraction. Tr. 562-63.

She testified that she had worked since her alleged onset date, from October 2005 to February 2006, at "Bear Creek" a call center for orders to Harry and David, a mail-order food company. Tr. 563. She had problems wearing the headset because of sores on her ears, behind her ears, and the side of her face. Id. She was let go because she had too many days and hours that she had missed work, and she could not work a full day. Tr. 564.

Plaintiff testified that she is unable to work because she sleeps poorly as a result of itching and scratching throughout the night, and has difficulty wearing clothes. Id. As a result, she often dresses in a mu-mu, or a light sarong, or something that is not binding to her body. Id. She constantly has creams and ointments on and is in and out of the shower. Id. She said she cannot get dressed professionally on a regular basis. Id.

Her skin feels hot and itchy and as a result of scratching, she gets lesions that burn. Tr. 565. When they heal, they itch more, creating a burning and itching cycle. Id. The lesions go from one spot to another, including her neck, her back, and then

her whole body. Id. The problem is systemic. Id.

Plaintiff cannot do many house chores because she cannot have her hands submerged in water. Tr. 566. Thus, she said she can do no diaper changes and no dishes. Id. She cannot cook because it requires too much time standing on her feet, which are cracked because of dryness. Id. She requires the use of a particular detergent for her clothes and is restricted to wearing clothes of a material that breathes. Tr. 567. She spends a lot of time in a cold shower, then lying on the bed naked with a fan, then applying creams and ointments or gels. Tr. 568.

Plaintiff noted that her ten-year history is one of taking high doses of steroids to control the condition, then concern by medical professionals about the high dose and recommendations that she "come off" the drug, followed by a hospitalization for a flare-up after which she is placed on the high dose again. Tr. 569. She again noted that she gets lesions on her hands and feet, and the longest she has responded to treatment has been one to two days. Tr. 570.

III. Vocational Expert Testimony

Vocational Expert (VE) Lynn Jones testified at the hearing. She noted plaintiff's past relevant work of order clerk, customer service work, and chiropractor assistant. Tr. 571. The ALJ presented the following hypothetical to the VE: a thirty-six year old person with plaintiff's education and past relevant work, who would miss more than two days of work per month on a routine basis. Id. In response, the VE stated that competitive employment was ruled out for such a person. Id.

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THE ALJ'S DECISION

The ALJ first determined that because of a previous disability application by plaintiff which she did not appeal following a denial on reconsideration, and because plaintiff presented no new and material evidence justifying the reopening of that prior application, plaintiff's onset date was no earlier than May 10, 2001. Tr. 13. References by the ALJ to medical or other evidence before the May 10, 2001 date were only for the purposes of establishing the nature and extent of plaintiff's impairments and addressing credibility. Id.

Next, the ALJ concluded that plaintiff had engaged in disqualifying substantial gainful work activity from December 1, 2001, through November 30, 2002. Tr. 16. Plaintiff does not object to this finding.

Following his finding that plaintiff's dermatitis was a medically determinable impairment, the ALJ concluded that it was not "severe" within the meaning of the regulations and that plaintiff did not have a severe impairment or combination of impairments. Tr. 16. Although explained in more detail below in the discussion section of this Opinion, generally speaking, the ALJ based his finding on three conclusions: (1) that because the exacerbations primarily occurred while plaintiff was pregnant, but still promptly responded to medical treatment, and because other flare ups occurred when she ran out of her medications, "her symptoms are largely volitional, and even when episodically active, they have been quickly controlled by medications"; Tr. 18; (2) the record supported the opinion of treating dermatologist Dr. Mendelson that the skin condition does not prevent plaintiff from

working; and (3) plaintiff's inconsistent statements and actions undermined her credibility. Tr. 18.

Because the ALJ concluded that plaintiff did not have a severe impairment that significantly limited her ability to perform basic work activities, she was not disabled under the statute. Tr. 21.

STANDARD OF REVIEW & SEQUENTIAL EVALUATION

A claimant is disabled if unable to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. § 423(d)(1)(A). Disability claims are evaluated according to a five-step procedure. Baxter v. Sullivan, 923 F.2d 1391, 1395 (9th Cir. 1991). The claimant bears the burden of proving disability. Swenson v. Sullivan, 876 F.2d 683, 687 (9th Cir. 1989). First, the Commissioner determines whether a claimant is engaged in "substantial gainful activity." If so, the claimant is not disabled. Bowen v. Yuckert, 482 U.S. 137, 140 (1987); 20 C.F.R. §§ 404.1520(b), 416.920(b). In step two, the Commissioner determines whether the claimant has a "medically severe impairment or combination of impairments." Yuckert, 482 U.S. at 140-41; see 20 C.F.R. §§ 404.1520(c), 416.920(c). If not, the claimant is not disabled.

In step three, the Commissioner determines whether the impairment meets or equals "one of a number of listed impairments that the [Commissioner] acknowledges are so severe as to preclude substantial gainful activity." Yuckert, 482 U.S. at 141; see 20 C.F.R. §§ 404.1520(d), 416.920(d). If so, the claimant is conclusively presumed disabled; if not, the Commissioner proceeds

to step four. Yuckert, 482 U.S. at 141.

In step four the Commissioner determines whether the claimant can still perform "past relevant work." 20 C.F.R. §§ 404.1520(e), 416.920(e). If the claimant can, he is not disabled. If he cannot perform past relevant work, the burden shifts to the Commissioner. In step five, the Commissioner must establish that the claimant can perform other work. Yuckert, 482 U.S. at 141-42; see 20 C.F.R. §§ 404.1520(e) & (f), 416.920(e) & (f). If the Commissioner meets its burden and proves that the claimant is able to perform other work which exists in the national economy, he is not disabled. 20 C.F.R. §§ 404.1566, 416.966.

The court may set aside the Commissioner's denial of benefits only when the Commissioner's findings are based on legal error or are not supported by substantial evidence in the record as a whole. Baxter, 923 F.2d at 1394. Substantial evidence means "more than a mere scintilla," but "less than a preponderance." Id. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Id.

DISCUSSION

Plaintiff contends that the ALJ made the following errors in determining that she did not have a severe impairment: the ALJ improperly rejected her testimony, improperly rejected Dr. Campbell's opinion, and based his decision on his own opinion without considering the record as a whole. Plaintiff also argues that after the error at step two, the ALJ further erred by failing to find that plaintiff's impairment(s) met or equaled a listed impairment at step three.

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I. Step Two Arguments

The ALJ considers the severity of the claimant's impairment(s) at step two. 20 C.F.R. §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii). If the claimant does not have a severe medically determinable physical or mental impairment that meets the duration requirement, or a combination of impairments that is severe and meets the duration requirement, the claimant is not disabled. Id.

A severe impairment is one that significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). "Basic work activities" are the abilities and aptitudes necessary to do most jobs, including physical functions such as walking, standing, sitting, lifting, etc.. 20 C.F.R. §§ 404.1521(b), 416.921(b). In Social Security Ruling (SSR) 96-3p (available at 1996 WL 374181, at *1), the Commissioner has explained that "an impairment(s) that is 'not severe' must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the ability to do basic work activities."

The Ninth Circuit has explained that the step two severity determination is expressed "in terms of what is 'not severe.'" Smolen v. Chater, 80 F.3d 1273, 1290 (9th Cir. 1996). The ALJ is required to consider the claimant's subjective symptoms, such as pain or fatigue, in determining severity. Id. Importantly, as the Ninth Circuit noted, "the step-two inquiry is a de minimis screening device to dispose of groundless claims." Id. (citing Yuckert, 482 U.S. at 153-54).

"[T]he severity regulation is to do no more than allow the [Social Security Administration] to deny benefits summarily to

those applicants with impairments of a minimal nature which could never prevent a person from working." SSR 85-28 (available at 1985 WL 56856, at *2) (internal quotation omitted). Therefore, "an ALJ may find that a claimant lacks a medically severe impairment or combination of impairments only when his conclusion is 'clearly established by medical evidence.'" Webb v. Barnhart, 433 F.3d 683, 687 (9th Cir. 2005) (quoting SSR 85-28). The court's task in reviewing a denial of benefits at step two is to "determine whether the ALJ had substantial evidence to find that the medical evidence clearly established that [the claimant] did not have a medically severe impairment or combination of impairments." Id.

A. Plaintiff's Testimony

The ALJ rejected plaintiff's subjective testimony based on several reasons discussed below. Plaintiff argues that the ALJ's reasons are not clear and convincing. I disagree.

The ALJ is responsible for determining credibility. Andrews v. Shalala, 53 F.3d 1035, 1039 (9th Cir. 1995). Once a claimant shows an underlying impairment and a causal relationship between the impairment and some level of symptoms, clear and convincing reasons are needed to reject a claimant's testimony if there is no evidence of malingering. Smolen, 80 F.3d at 1281-82. When determining the credibility of a plaintiff's complaints of pain, the ALJ may properly consider several factors, including the plaintiff's daily activities, inconsistencies in testimony, effectiveness or adverse side effects of any pain medication, and relevant character evidence. Orteza v. Shalala, 50 F.3d 748, 750 (9th Cir. 1995). The ALJ may also consider the ability to perform household chores, the lack of any side effects from prescribed

medications, and the unexplained absence of treatment for excessive pain when determining whether a claimant's complaints of pain are exaggerated. Id.

The ALJ first found that plaintiff's seeking a disability opinion from Dr. Campbell after Dr. Mendelson refused to provide her with one, was "doctor shopping" which undermined her credibility. Tr. 21. The record supports the ALJ's finding.

Soon after plaintiff moved to Oregon in June 2005, she sought treatment from the Family Practice Group in Medford, where she lived. Tr. 461. She then saw Dr. Mendelson in August 2005. Tr. 540. After only one visit and one telephone call, plaintiff requested a disability opinion from Dr. Mendelson in September 2005, and Dr. Mendelson refused to provide her with one. Tr. 539. Plaintiff then started seeing Dr. Campbell, apparently as her primary care physician, in Jacksonville, even though she had seen someone in Medford, closer to where she lived, only a couple of months before. Tr. 533-34. Then, after only several months of seeing Dr. Campbell, and after obtaining the desired disability opinion she requested from him, she returned to the Family Practice Group in Medford in May 2006, reporting that she did not have a primary care physician. Tr. 485. Despite several recommendations to see her dermatologist, plaintiff never returned to Dr. Mendelson for treatment of her skin problem, although she did see her in May 2007 for a skin check following the excision of a squamous cell cancer lesion. Tr. 538.

The ALJ's decision indicates that he viewed the September 13, 2005 chart note made by Dr. Mendelson's assistant, as an opinion by Dr. Mendelson that plaintiff's skin condition was not disabling.

Although the chart note at issue does not directly express Dr. Mendelson's opinion, the ALJ's interpretation of the chart note is not unreasonable. As such, I must accept it. Edlund v. Massanari, 253 F.3d 1152, 1156 (9th Cir. 2001) ("The ALJ is responsible for determining credibility, resolving conflicts in medical testimony, and resolving ambiguities"; "[i]f the evidence is susceptible to more than one rational interpretation, the court may not substitute its judgment for that of the Commissioner.").

Additionally, the ALJ's interpretation that plaintiff was "doctor shopping" is not unreasonable. The string of facts with plaintiff having initially started primary care in Oregon with the Family Practice Group in Medford, then seeking treatment for her skin condition from Dr. Mendelson, followed by starting care with a different primary care practitioner in a more distant location after Dr. Mendelson refused to provide plaintiff with a disability opinion, followed by returning to the Family Practice Group in Medford for primary care after obtaining the desired disability opinion from Dr. Campbell, and not treating with Dr. Mendelson for her skin condition again despite consistent advice to do so, suggests plaintiff's actions were motivated by something other than establishing care for the purposes of treatment. While that is not the only possible interpretation of the facts, it is not an unreasonable one. Accordingly, I accept it.

Next, the ALJ concluded that although plaintiff testified that she was physically unable to care for herself, the record noted her as a "homemaker." Tr. 21. The references cited by the ALJ as showing plaintiff a "homemaker," are found in computerized printouts from the Torrance Memorial Medical Center in Torrance,

California, when plaintiff was treated in the emergency room. Tr. 200 (June 2004), 229 (January 2004), 240 (October 2003). The printouts list information about the patient, the patient's employer, health insurance, and physician, and admission information. Id.

There are two problems with the ALJ's reliance on these records to discredit plaintiff's testimony. First, there is no indication that plaintiff herself provided the term "homemaker." It is simply listed in the employer section as her occupation, with other employer-related information blank. Id. Plaintiff may well have described her situation as staying home with children, which someone else described as "homemaker."

Second, while the term "homemaker" carries some implication of tending to a home, and perhaps children, the simple listing on a computerized form of the word "homemaker" insufficiently describes what was meant by that word. It reveals nothing about her daily activities. The term, without more, is not descriptive of what plaintiff was actually able to do physically at that time. Therefore, I agree with plaintiff that this particular reason for rejecting plaintiff's testimony is not clear and convincing.

The third reason given by the ALJ for rejecting plaintiff's testimony is that the record referred to plaintiff being a student, undermining evidence that she is unable to do anything other than take care of her children. Tr. 21. The reference to plaintiff attending school is in a March 13, 2007 chart note from an emergency room visit by plaintiff for a left foot sprain. Tr. 457. The record indicates that as a result of the foot injury, plaintiff was going to rely on a wheelchair rather than crutches for mobility

because she was in school and would be unable to carry books and walk between classes on crutches. Id.

The record supports the ALJ's determination that plaintiff's status as a student undermines her credibility. In addition to evidence that she could do few chores and spent time only tending to her children, plaintiff herself testified at the hearing that (1) she had trouble writing when her hands were cracked, (2) she was unable to work for a variety of reasons including poor sleep, inability to wear professional clothes, the need to be in and out of the shower, the need to lie naked on her bed with a fan, and (3) her constant itching causing burning lesions, and that she could not be on her feet. The fact that only two months prior to giving this testimony, plaintiff was a student taking what appears to be more than one class, contradicts the evidence regarding her limitations and is a clear and convincing basis upon which to find her limitations testimony not credible.

The last reason given by the ALJ for rejecting plaintiff's testimony is her failure to follow up with the dermatologist and her non-compliance in seeking treatment with an allergist. Tr. 21. The ALJ cites to Dr. Mendelson's August 17, 2005 chart note of plaintiff's first visit with Dr. Mendelson. Tr. 540. After prescribing a course of treatment, Dr. Mendelson stated that plaintiff would return to the clinic as necessary. Id.

Although the record unquestionably shows that plaintiff continued to have problems with her skin, she never returned to see Dr. Mendelson for her skin problem. She called once to report that she was out of prednisone and another time to request a disability opinion, but she did not return to see Dr. Mendelson for treatment

of dermatitis. When she did see Dr. Mendelson again, in May 2007, it was for a skin cancer issue, not her chronic dermatitis condition. Plaintiff's failure to continue treatment with Dr. Mendelson shows, at a minimum, a lack of effort by plaintiff to pursue care from a specialist.

The ALJ next cites to Dr. Campbell's February 9, 2006 note in which he encourages her to return to her dermatologist for treatment. Tr. 521. Plaintiff failed to follow his advice. He also encouraged her to see a rheumatologist and an endocrinologist. Id. He indicated he would wait to make those referrals until after plaintiff had seen the dermatologist. Plaintiff's failure to follow up with dermatology as Dr. Campbell recommended precluded her from obtaining referrals to other specialists who might have offered different treatment for plaintiff's skin condition.

As for the allergist, an emergency room physician treating plaintiff in February 2005 advised plaintiff to obtain an allergy referral from her primary care physician. Tr. 277. Plaintiff apparently never did so until more than two years later when it was arranged by Dr. Peterson.

It is not unreasonable to view plaintiff's repeated failures to follow up with specialists as revealing that she is more interested in being found disabled than in obtaining effective treatment. The ALJ did not err in finding her not credible for failing to pursue these recommendations. Tommasetti v. Astrue, 533 F.3d 1035, 1039 (9th Cir. 2008) (ALJ may rely on unexplained or inadequately explained failure to seek treatment or to follow a prescribed course of treatment to reject testimony regarding severity of symptoms).

The ALJ did not err in rejecting plaintiff's subjective testimony based on finding her not credible. Even though one of the reasons supplied by the ALJ is not supportable, the ALJ provided other clear and convincing reasons, supported by substantial evidence in the record, for his decision. This is sufficient. Batson v. Commissioner, 359 F.3d 1190, 1197 (9th Cir. 2004) (substantial evidence still supported ALJ's credibility determination even though ALJ erred in making one assumption not supported by the record). Here, the ALJ did not base his decision on his own opinion or fail to consider the whole record.

B. Dr. Campbell's Opinion

Plaintiff argues that the ALJ improperly rejected Dr. Campbell's March 2006 opinion in which he stated that plaintiff was limited by her skin condition and the side effects of her medication, and was a good candidate for disability. Tr. 404.

Social security law recognizes three types of physicians: (1) treating; (2) examining; and (3) nonexamining. Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1996). Generally, more weight is given to the opinion of a treating physician than to the opinion of those who do not actually treat the claimant. Id.

If the treating physician's opinion is not contradicted, the ALJ may reject it only for "clear and convincing" reasons. Id. Even if the treating physician's opinion is contradicted by another doctor, the ALJ may not reject the treating physician's opinion without providing "specific and substantial reasons" which are supported by substantial evidence in the record. Id.

The ALJ gave several reasons for rejecting Dr. Campbell's opinion. First, he noted that Dr. Campbell had treated plaintiff

for only seven months, during which time plaintiff had experienced only two skin exacerbations. Tr. 20. The weight accorded a treating physician's opinion depends on the length of the treatment relationship, the frequency of visits, and the nature and extent of treatment received. 20 C.F.R. §§ 404.1527(d)(2)(i), (ii), 416.927(d)(2)(i), (ii).

The record shows that Dr. Campbell saw plaintiff seven times during his seven-month relationship with her, and that her skin condition was not her chief complaint or reason for the visit on any of those occasions. Tr. 533 (September 15, 2005 visit to establish care and address right wrist pain); Tr. 530 (November 15, 2005 visit to address hypertension and diabetes which occurred during previous pregnancy); Tr. 529-30 (January 20, 2006 visit to follow up on hypertension and diabetes and report chest pain); Tr. 522-23 (January 30, 2006 visit to follow up on laboratory tests, complaint of right ankle pain); Tr. 521 (February 9, 2006 visit to follow up on dipyridamole thallium scan regarding potential heart problems); Tr. 517-18 (February 16, 2006 visit to follow up on diabetes and discuss social security); Tr. 515 (March 9, 2006 visit to discuss social security paperwork).

Although Dr. Campbell noted plaintiff's chronic dermatitis, described her skin condition, and prescribed medications for the condition, his primary treatment relationship with plaintiff was for issues and concerns other than her dermatitis. During the time he saw her, she experienced two flare-ups which Dr. Campbell noted. Tr. 523 (January 30, 2006); Tr. 518 (February 16, 2006). However, neither time was that the basis for her appointment with him.

There is no question that Dr. Campbell was a treating

physician. But, the ALJ's interpretation of the evidence as indicating that Dr. Campbell's opinion is entitled to little or no weight because the treatment relationship was relatively short and because the nature of the relationship was generally for non-skin related conditions, is supported by the record. The ALJ did not err in this regard.

Next, the ALJ rejected Dr. Campbell's opinion because Dr. Campbell had accepted at face value that plaintiff had ceased her last job because of her skin condition, but Dr. Campbell did not have the benefit of the record showing that she stopped working when she was three months pregnant. Tr. 20.

The job referred to by Dr. Campbell was one of medical "front office person," a position plaintiff held in 2002. Tr. 404. Although the ALJ miscalculated how pregnant plaintiff was when she left the position in November 2002, Tr. 359 (August 3, 2002 chart note referring to plaintiff's twelve-week pregnancy, making her approximately seven months pregnant in November 2002), the ALJ appropriately noted that when Dr. Campbell rendered his opinion as to plaintiff's disability, and in particular, when he noted in that opinion that plaintiff stopped working in 2002 because of her skin condition, Dr. Campbell had no evidence regarding plaintiff's reason for quitting her job other than plaintiff's self-report.

The ALJ may reject a treating physician's opinion when that opinion is based on the plaintiff's subjective complaints and when the ALJ has properly rejected the plaintiff's subjective testimony. See Tonapetyan v. Halter, 242 F.3d 1144, 1149 (9th Cir. 2001) (when the record supported the ALJ in discounting the plaintiff's credibility, the ALJ was free to disregard the physician's opinion

which was premised on the plaintiff's subjective complaints); Morgan v. Commissioner, 169 F.3d 595, 602 (9th Cir. 1999) (A physician's opinion of disability premised to a large extent upon the claimant's own accounts of his symptoms and limitations may be disregarded where those complaints have been "properly discounted) (internal quotation omitted).

Because the ALJ has properly discounted plaintiff's testimony, he may properly reject this basis of Dr. Campbell's opinion because it relies on nothing but plaintiff's own report to Dr. Campbell. Moreover, nowhere in Dr. Campbell's chart notes does he mention plaintiff's skin condition affecting her ability to work or her activities of daily living. His chart notes reveal no notation of her having to quit work in the past. Additionally, the medical records during the period leading up to late November 2002 when plaintiff quit the medical front office person job, show no acute exacerbations of her skin condition during that time. Tr. 352-57. Her last flare-up, almost four months before she quit work, was in early August when she had stopped taking prednisone early in her pregnancy. Tr. 360. Thus, the record as a whole supports the ALJ's rejection of Dr. Campbell's statement, based on plaintiff's self-report, that plaintiff's skin condition caused her to quit work in 2002.

The ALJ next rejected Dr. Campbell's opinion because, according to the ALJ, Dr. Campbell contradicted himself when he noted significant side effects of plaintiff's treatment with steroids, including elevated blood pressure, blood sugar, and weight gain, in contrast to the record which showed that the hypertension was benign and improved on medication, plaintiff had

no cardiac disease, and the elevated blood sugar and weight gain first appeared during pregnancy, a time when plaintiff used less or no steroids. Tr. 20. Moreover, the ALJ noted that while plaintiff was subsequently diagnosed with Type II diabetes, the record showed that it was controlled with diet and medication. Id.

I agree with the ALJ. Contrary to what Dr. Campbell suggested in his March 2006 opinion, Dr. Campbell's notes do not indicate that the side-effects of plaintiff's prednisone use compromise plaintiff's ability to work. Indeed, there is no record of many of the possible side effects ever afflicting plaintiff.

As the ALJ remarked, plaintiff's diabetes originally appeared as gestational diabetes during pregnancy, Dr. Campbell referred to it as borderline, and it was controlled with medication and diet. Tr. 528. The hypertension also appeared initially during pregnancy and Dr. Campbell himself reported it as benign. Tr. 528. Plaintiff herself reported in December 2006 that she had no known complications as a result of her long-term steroid therapy. Tr. 481. Thus, Dr. Campbell's opinion that the hypertension and diabetes were caused by plaintiff's steroid use and that they produce limitations on her abilities, is unsupported by Dr. Campbell's own chart notes and other medical evidence in the record.

The ALJ also determined that Dr. Campbell's recitation of other side effects of plaintiff's long-term steroid use such as loss of visual acuity, decreased ability to concentrate, mood fluctuations, difficulty writing, and difficulty walking, were based only on plaintiff's self-report and were not supported by the record as no such symptoms appeared anywhere in the record. Tr.

20. I agree with the ALJ and note again his freedom to reject medical opinions premised on subjective reports from discredited witnesses.

There is no mention of these other side effects in any part of the medical record, including no notations by Dr. Campbell that plaintiff had even reported these symptoms to him or any other medical provider. The only part of the administrative record to note any of these other alleged side effects, if at all, is the transcript of plaintiff's hearing testimony. Thus, while the dermatitis may well be a life-long condition requiring ongoing corticosteroid treatment, Dr. Campbell's opinion that the treatment's side effects included a loss of visual acuity, decreased ability to concentrate, mood fluctuations, and difficulty walking, is not supported by the medical evidence. The record also does not support the suggestion that any of these conditions, if they exist, are in any way disabling.

The ALJ concluded his discussion of Dr. Campbell's opinion by noting that when Dr. Campbell's opinion is considered in conjunction with treating dermatologist Dr. Mendelson's refusal to state that plaintiff was unable to work because of the skin condition, Dr. Campbell's opinion was nothing more than advocacy and could not be accepted. The record supports the ALJ's interpretation of the evidence. A specialist's opinion carries more weight than that of a primary care provider. 20 C.F.R. §§ 404.1527(d)(5), 416.927(d)(5) (opinion of specialist accorded more weight). Given Dr. Mendelson's refusal to support plaintiff's quest for disability, and given the lack of medical evidence supporting much of Dr. Campbell's opinion, the ALJ's interpretation

of Dr. Campbell's role is not unreasonable.

The ALJ's rejection of Dr. Campbell's opinion is based on the whole record, is not based on the ALJ's own opinion, and is not in error.

III. What the Record Establishes

Even without considering plaintiff's testimony or Dr. Campbell's opinion, the medical evidence in the record establishes unequivocally that plaintiff suffers from a chronic skin condition with periodic exacerbations. However, the record shows that most of plaintiff's flare-ups occurred during pregnancy or when she ran out of prednisone. Thus, the ALJ's assertion that plaintiff herself created situations in which exacerbations were likely to occur, is based on substantial evidence in the record.

Additionally, although her flare-ups occasionally required administration of intravenous medications, the acute symptoms usually resolved fairly quickly and thus, the record does not support a finding that any limitations on plaintiff's basic work activities would meet the duration requirement. Accordingly, while plaintiff has an impairment, the record as a whole supports the ALJ's conclusion that it is not severe at step two.

Finally, plaintiff argues that the combination of her impairments, and not just the skin condition alone, supports a finding of severity at step two. As I understand the argument, plaintiff contends that the skin condition, plus her other alleged impairments noted at page three of this Opinion & Order, support a severity determination. I disagree.

First, without the skin condition being severe, her argument is unavailing. Second, even considering the skin condition as it

is, and not as a severe impairment, the combination of her impairments still does not require a step two finding in her favor. Plaintiff does not argue in this case that the ALJ erred when he found that she had no medically determinable mental impairment. Tr. 18. And, there is nothing in the record to support any limitations on plaintiff's basic work activities caused by ovarian cysts or migraines. There is no support in the medical record for finding an "ADD" impairment. Thus, even when all other alleged conditions are considered in combination and with the skin condition, they do not support a finding of "severe" at step two.

IV. Step Three Argument

Plaintiff argues that not only did the ALJ err in finding her impairment "not severe" at step two, but the evidence in the record supports a determination that her impairment meets or equals a listed impairment at step three.

The listed impairments cited by plaintiff are 8.00 and 8.05, found at 20 C.F.R. Pt. 404, Subpt. P, App. 1, Listing 8.00 and 8.05. Listing 8.00 provides general information about how the Commissioner evaluates skin disorders. Listing 8.05 is more specific and addresses dermatitis. It provides that dermatitis (including atopic dermatitis, and exfoliative dermatitis), will be considered a listed impairment if it causes "extensive skin lesions that persist for at least 3 months despite continuing treatment as prescribed." 20 C.F.R. Pt. 404, Subpt. P, App. 1, Listing 8.05.

Because the ALJ did not err in his step two determination, I need not reach this step three argument. However, I note that the record does not demonstrate that plaintiff's baseline skin condition, absent flare-ups, produces "extensive skin lesions."

The record also does not clearly demonstrate that the flare-ups produce extensive skin lesions which last for at least three months. Thus, finding that plaintiff's impairment meets or equals a listed impairment is not supported in this record.

CONCLUSION

The Commissioner's decision is affirmed.

IT IS SO ORDERED.

Dated this 13th day of March, 2009.

/s/ Dennis James Hubel
Dennis James Hubel
United States Magistrate Judge